Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Seton Medical Center Williamson

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-15-2401-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
April 3, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As the medical report shows, the procedures were medically necessary; therefore, the hospital has a right to expect reimbursement."

Amount in Dispute: $454.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent contends the treatment sought by the Claimant on 8/7/14 was not a true emergency. The records show the Claimant was having pain for several days. Therefore, the Claimant had ample time to contact his treating physician to obtain an appointment or a referral for an appointment. The fact that the Claimant waited several days to obtain treatment also indicates the treatment was not an emergency."

Response Submitted by: Downs ♦ Stanford, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 7, 2014	Outpatient Hospital Services	$454.51	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of healthcare.
3. 28 Texas Administrative Code §133.2 defines an emergency.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notification absent
   - P13 – Payment reduced or denied based on workers compensation jurisdictional regulations or payment policies

Issues

1. Does the disputed service(s) require pre-authorization?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code, 197 – "Precertification/authorization/notification absent." 28 Texas Administrative Code §134.600 (c) states, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions)..." 28 Texas Administrative Code §133.2(5)(A) states that, "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily function in serious jeopardy, or (ii) serious dysfunction of any body organ or part." The medical documentation does not meet the definition of an emergency pursuant to §133.2(5)(A). For example:
    a. Emergency Physician Record (page 22 of 54) onset / duration "several days".
    b. Emergency Documentation (page 24 of 54) Hx of Present Illness/Mech of Inj/Onset. "hx of chronic back pain worsened since yesterday"

   The definition of an emergency has not been met. The denial code is supported.

2. Requestor did not support definition of medical emergency therefore, prior authorization was required.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 14, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.